CRITICAL ILLNESS CLAIM FORM
Golden Rule Insurance Company

Golden Rule®
A UnitedHealthcare Company

Instructions for Filing a Claim:

1. Fill out this form completely. Failure to do so could result in a delay in processing this claim.
   a. Complete Parts 1, 2, and 3: Primary Insured & Patient Information, Reason for Claim, and Physician History.
   b. Have the treating physician complete Part 4: Treating Physician's Statement.

2. Parts 1-4 must be submitted along with the required supporting documents and signed medical authorization. (Supporting documents are identified in Part 5.)

Mail or fax all forms and documents to: **Golden Rule Insurance Company**
Claims Department
PO Box 31375
Salt Lake City, UT 84131-0375

Fax to: (801) 478-7582

If there are any questions about what benefits are covered or how to use this form, please contact our customer service department at **(800) 657-8205**, or refer to the Critical Illness Insurance Policy.

PART 1: PRIMARY INSURED & PATIENT INFORMATION

Primary Insured Name:		Policy Number:	
Address:	City:	State:	ZIP Code:
Daytime Phone Number:			
Patient Name (Covered Person under the Policy):		Date of Birth:	

PART 2: REASON FOR THIS CLAIM

☐ Carcinoma in Situ ☐ Coma ☐ Coronary Artery Bypass Graft ☐ Heart Attack ☐ Life Threatening Cancer

☐ Loss of Hearing ☐ Loss of Speech ☐ Loss of Vision ☐ Major Transplant ☐ Paralysis ☐ Renal Failure ☐ Stroke

PART 3: PHYSICIAN HISTORY

List all physicians that have provided treatment to the patient within the past 12 months. (Attach a separate sheet if necessary.)

Physician Name *(Please Print)*:			
Physician Address:	City:	State:	ZIP Code:
Physician Phone Number:	Date(s) Consulted:		
Diagnosis and/or Treatment:			
Physician Name *(Please Print)*:			
Physician Address:	City:	State:	ZIP Code:
Physician Phone Number:	Date(s) Consulted:		
Diagnosis and/or Treatment:			

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

Authorization to obtain and disclose health information:

I authorize any health care provider or facility, pharmacy, government agency, insurance company or benefit plan administrator having information as to the care, advice, treatment or diagnosis of the patient named below, to provide any and all of this information to Golden Rule Insurance Company, a UnitedHealthcare company, or any agent or independent administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request, and that I have the right to revoke any authorization by notifying Golden Rule Insurance Company in writing. I understand that revocation of or failure to sign an authorization may impair Golden Rule Insurance Company's ability to evaluate or process a claim, and may be the basis for denying claims for benefits. A covered entity disclosing information pursuant to this authorization may not condition treatment, payment, or eligibility for benefits on whether the individual signs this authorization. A copy of this shall be as valid as the original. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by the federal privacy law (45 CFR Parts 160 and 164, *et seq.*).

The purpose of this authorization is to process a claim for benefits. This authorization is valid for 12 months from the date signed.

Warning: Any person who knowingly and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing false, incomplete, or misleading information may be guilty of a crime and may be prosecuted under state law. Penalties may include imprisonment, fines, and denial of insurance benefits.

_____

Name of Patient *(Please print)*

X _____ _____

Signature of Patient **Date**

PART 4: TREATING PHYSICIAN'S STATEMENT

Patient Name:		Date of Birth:	
Physician Name *(Please Print)*:			
Physician Address:	City:	State:	ZIP Code:
Physician Phone Number:	Physician Fax Number:		

Date of first visit for this condition ____/____/____

Date of diagnosis for this condition ____/____/____

Was this condition a result of an injury? ☐Yes ☐No Date of injury: ____/____/____

Was the patient hospitalized for this condition? ☐Yes ☐No Admission Date: ____/____/____ Discharge Date: ____/____/____

Hospital Name:			
Hospital Address:	City:	State:	ZIP Code:

List all dates of service/diagnosis/procedures for which you have seen the patient. (Attach a separate sheet if necessary.)

Date(s) of Service	Diagnosis Code (ICD)	Diagnosis Description	Procedure Code (CPT)	Procedure Description

Has the patient ever been diagnosed with a similar condition? *(If yes, provide dates and description.)*
Does the patient suffer from any chronic illnesses? *(If yes, provide details on illness.)*
Does the patient take any prescription medications on a regular basis? *(If yes, list all medications.)*

List the name, address, and phone number of any other physician that has treated the patient for this condition.

Referring Physician Name:	Address/Phone Number:
Referring Physician Name:	Address/Phone Number:

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X _____ _____

Physician Signature **Date**

_____

Tax ID Number

PART 5: SUPPORTING DOCUMENTS

*The following documentation is **required** in order to process this claim for benefits.*
(Additional information may be requested to determine benefits.)

Carcinoma In-Situ

Pathology report confirming the pathological diagnosis of in-situ cancer that affects only the area of the body in which it began, has not spread and, is classified by pathology. Documentation from a board certified medical doctor, substantiating the diagnosis.

Coma

Hospital records and test results (Glasgow Coma Scale) from initial onset substantiating a state of unconsciousness, characterized by the absence of any voluntary, purposeful movement, from which the covered person cannot be aroused. Documentation from a board certified medical doctor, substantiating the diagnosis and neurological deficits.

Coronary Artery Bypass Graft

Surgical report for coronary artery revascularization surgery which uses a saphenous vein or internal mammary artery graft to surgically bypass obstructions. Techniques that do not involve open heart surgery, such as balloon angioplasty, laser relief of an obstruction and/or other intra-arterial procedures are not covered.

Heart Attack

Documentation from a board certified medical doctor substantiating a diagnosis of a new myocardial infarction, including a new electro-cardiogram indicating changes consistent with an acute myocardial infarction, laboratory results and confirmatory imaging studies.

Life Threatening Cancer

Pathology report, operative report (if available), and laboratory records substantiating malignant neoplasm (including hematologic malignancy). Documentation from a board certified medical doctor substantiating a diagnosis.

Loss of Hearing

Documentation from board certified medical doctor specializing in the field of hearing substantiating the diagnosis. Also needed are audiometric and sound threshold test results.

Loss of Speech

Documentation from board certified medical doctor specializing in the field of speech substantiating an irreversible total loss of speech.

Loss of Vision (Blindness)

Documentation from board certified medical doctor specializing in the field of ophthalmology substantiating a diagnosis of irreversible reduction in sight.

Major Transplant

Documentation from a board certified medical doctor substantiating surgery where the covered person is a recipient of a transplant.

Paralysis

Documentation from a board certified medical doctor substantiating diagnosis of total and irreversible paralysis.

Renal (Kidney) Failure

Documentation from a board certified medical doctor substantiating a diagnosis of end stage renal disease and chronic, irreversible failure of the function of both kidneys requiring hemodialysis and necessitating kidney transplant.

Stroke

Documentation from a board certified medical doctor substantiating persistent neurological damage and deficits, neuroimaging studies supporting the new diagnosis of brain tissue infarction due to acute cerebrovascular incident, embolism, thrombosis or hemorrhage.